



STATE OF MISSOURI
DEPARTMENT OF INSURANCE
FRAUD INVESTIGATION REPORT (CONSUMER)

CONFIDENTIAL

This report and the attached documents are confidential to the extent provided under section 375.993 of the Revised Statutes of Missouri.

INSTRUCTIONS

Please complete all items below and enclose copies of any correspondence or other papers which you feel would help the investigation of this report. Print your name, sign and date in the spaces given.

Send completed form along with any attachments to:

Consumer Fraud Unit
Department of Insurance
P.O. Box 690
Jefferson City, Missouri 65102-0690
Telephone: (573) 751-2640
Telecommunications Device for the Deaf (TDD) Number: (573) 526-4536

PLEASE PRINT, TYPE OR WRITE CLEARLY

1. NAME OF COMPANY		TELEPHONE NUMBER ()
MAILING ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)		
2. NAME OF INSURED		
2a. EMPLOYER NAME (IF GROUP POLICY)		
MAILING ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)		
3. WHO IS COMPLAINT AGAINST? (NAME OF CONSUMER, INSURANCE LICENSEE, ETC.)		
ADDRESS, IF KNOWN (STREET) (CITY) (STATE) (ZIP CODE)		
4. GROUP OR CERTIFICATE NUMBER	POLICY OR I.D. NUMBER	EFFECTIVE DATE
5. CLAIM NUMBER	AGENT NAME (IF APPLICABLE)	DATE OF LOSS
NATURE OF COMPLAINT <input type="checkbox"/> LIFE <input type="checkbox"/> GROUP HEALTH <input type="checkbox"/> INDIVIDUAL HEALTH <input type="checkbox"/> AUTO <input type="checkbox"/> LIABILITY <input type="checkbox"/> FIRE HOMEOWNERS <input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> OTHER (SPECIFY) ►		

DETAILS OF COMPLAINT (USE BACK IF NECESSARY)

PRINT YOUR NAME

YOUR SIGNATURE
►

DATE